Getting Started

You can fill out the Senior Medical Benefit Request (SMBR) on your computer, then print it. Or, you can print a blank copy and fill it out by hand. Make sure you sign and date the SMBR on page 10. Then send it with proof of your income and assets to the one MassHealth Enrollment Center (listed on the SMBR instruction page) that is closest to where you live.

To fill out the SMBR on-line, use the mouse to **click** on the first field you want to fill out **on each page**. Type the necessary information, then press the Tab key to move to the next field, or use the mouse to click on the next field. To fill a check box, click on the box using the mouse, or tab to the field, and when the box has a dotted line around it, press the Enter key. If you need to go back to another field, click on that field with your mouse. To go from one page to the next, tab to "Please go to the next page.", and when highlighted, press tab or hit enter, or use the mouse to click on the first field on each page.

After you print the filled-out SMBR, YOU MUST click on the "Clear entire form" button at the bottom of page 10. This will remove all the information you entered on the SMBR so no one can see your personal information.

Fill out form

Print blank form

Back to "Get the MassHealth Application Forms Index" main page

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Senior Medical Benefit Request

for Seniors and People Needing Long-Term-Care Services

Instruction Page

NOTE: Information entered into this form cannot be saved, so be sure to print a copy of the completed form before closing it.

Please read these instructions before you fill out the application.

Dear Applicant:

This is your application for MassHealth and the Uncompensated Care Pool* if you live in Massachusetts and:

- are aged 65 or older and living at home;
- are any age and need long-term-care services in a medical institution;
- are eligible under certain programs to get long-term-care services to live at home; or
- are a member of a married couple living with your spouse and
  - both you and your spouse are applying for MassHealth; and
  - there are no children under 19 living with you; and
  - one spouse is 65 years of age or older and the other spouse is under 65 years of age. (Please read page 9.)

You will also need to fill out Supplement A: Long-Term-Care Questions (see blue sheet) if you are:

- in an institution, like a nursing home, chronic hospital, or other medical institution; or
- in an acute hospital waiting for placement in a long-term-care facility.

After your application is filled out and reviewed, **you will be given the most complete coverage that you qualify for**.

There is a different application for you, called a Medical Benefit Request (MBR), if you are:

- any age and both disabled and working 40 or more hours a month, and not living with your spouse aged 65 years or older;
- under age 65 and not in a medical institution, and you do not need long-term-care services; or
- aged 65 or older and a parent or caretaker relative of children under age 19.

To get the MBR, call the MassHealth Customer Service Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people with partial or total hearing loss).

This application package contains:

- a Senior Medical Benefit Request **(orange form)**;
- the **MassHealth and You** guide, which explains who is eligible for MassHealth, what the income and asset rules are, what medical services you can get under MassHealth, and what your rights and responsibilities are;
- a MassHealth Eligibility Representative Designation Form (If you want someone to act on your behalf, you can use this form to tell us who this person is.);
- an IRS Form 4506; and
- a Personal-Care-Attendant Supplement **(gold form)**.

*This information will be used to determine low-income patient status for provider payments from the Uncompensated Care Pool.

over ▶

When you fill out the Senior Medical Benefit Request, remember to:

- Read carefully the *MassHealth and You* guide before you fill out the application. Keep the guide. It may answer questions you have later.
- Answer all questions and fill out all sections that apply to you on the application and, if necessary, the gold form. If you need more space, use a separate sheet of paper, and attach it to the application.
- Send proof of all current income before deductions, like copies of pension check stubs. (You do not have to send proof of social security income.)
- Send proof of all assets, like bank accounts and life-insurance policies.
- Send a copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not U.S. citizens and are applying for MassHealth, except for MassHealth Limited or the Uncompensated Care Pool.
- Send copies of your current health-insurance premium bills if you are applying for long-term-care services in a medical facility. (You do not have to send copies of your Medicare cards.)
- Sign and date all the forms after you finish filling them out. If you are married, your spouse must also sign.
- Submit a filled-out MassHealth Eligibility Representative Designation Form, if you are filling out this application as an eligibility representative or if you want someone to act on your behalf.
- Send the filled-out Senior Medical Benefit Request and gold form, if needed, and any needed papers to the one MassHealth Enrollment Center (MEC) listed below that is closest to where you live.

Revere MEC	Taunton MEC
300 Ocean Avenue	21 Spring Street
Suite 4000	Suite 4
Revere, MA 02151	Taunton, MA 02780
Springfield MEC	Tewksbury MEC
333 Bridge Street	367 East Street
Springfield, MA 01103	Tewksbury, MA 01876

If you need more information about how to apply, or if you need another copy of the Personal-Care-Attendant Supplement for your spouse who is also applying, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

If you want us to share information about your MassHealth eligibility (including copies of notices we send you) with someone other than your eligibility representative, if you have one, please call MassHealth. MassHealth can give you a MassHealth Permission to Share Information Form.

If you have any questions about any form or the information you need to send, please call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss).

Click here to fill out the form.

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Senior Medical Benefit Request

for Seniors and People Needing Long-Term-Care Services

This form is valid only if it has not been altered in any way, other than by entering the information requested.

IMPORTANT: Please do not leave this information on your computer screen where unauthorized persons may be able to read confidential personal information.

This is an application for MassHealth and the Uncompensated Care Pool. You do not have to be a U.S. citizen to get MassHealth. Please print clearly. Answer all questions and fill out all sections. If you need more space to finish any section on this form, please use a separate sheet of paper and attach it to the application.

You MUST answer ALL three questions in the following section.

Are you or your spouse applying for:

1. MassHealth/the Uncompensated Care Pool while still living at home, in a rest home, or in assisting living? . . . . . You ☐ yes ☐ no Your spouse ☐ yes ☐ no
2. MassHealth while still living at home, in a rest home, or in assisted living AND also either applying for or getting services from Home- and Community-Based Services Waiver, PACE (Program of All-Inclusive Care for the Elderly), or SCO (Senior Care Options)? . . . . . You ☐ yes ☐ no Your spouse ☐ yes ☐ no
3. MassHealth because you are living in a medical institution, like a nursing home or chronic hospital? . . . . . You ☐ yes ☐ no Your spouse ☐ yes ☐ no

If you are applying for or getting services in a nursing home or chronic hospital, you **must** fill out the blue sheet (Supplement A: Long-Term-Care Questions) at the end of this application.

Head of Household/Applicant

HOH

Last name	First name	MI	Street address

City	State	Zip	Mailing address *(if different from street address or if living in a shelter)* ☐ homeless

Marital status ☐ single ☐ married ☐ separated ☐ widowed ☐ divorced	Is this person a U.S. citizen? ☐ yes ☐ no	Social security number*	Date of birth	Sex ☐ M ☐ F	Race *(optional)*

Spoken language choice	Written language choice	Ethnicity *(optional)*	Telephone numbers *(List work number only if we can call you at work.)* Home: Work:

Name and address of hospital, nursing facility, or other institution (if applicable)	Date of admission

Spouse Information

HOH

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If yes, is this person a U.S. citizen? ☐ yes ☐ no	Social security number*

Date of birth	Sex ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*

Address, if different from head of household	Is this a hospital, nursing facility, or other institution? ☐ yes ☐ no

Previous Medical Bills

RET

Do you or your spouse have bills for medical services you got in the three months before the month we got your application? ☐ yes ☐ no

If **yes**, fill out the rest of this section.
We may be able to pay for these bills.
If **no**, go to the next section (Previous Assistance).

Do you or your spouse want to apply for MassHealth for that time period? . . . . . ☐ yes ☐ no

If **yes**, what is the earliest date for which you need MassHealth?

(You must give us proof of all income and assets owned during that time period.)

Previous Assistance

SSI

Have you or your spouse ever gotten Supplemental Security Income (SSI)? . . . . . You ☐ yes ☐ no Your spouse ☐ yes ☐ no

If **yes**, fill out the rest of this section.
If **no**, go to the next section (Personal-Care-Attendant Services).

When did you or your spouse last get SSI? . . . . . .
You Your spouse

Do you (Please check ☑ one.) ☐ live in own home? ☐ share expenses with another/others? ☐ live in someone else's home? ☐ live in a rest home? ☐ live in an assisted-living facility?

* Not required if applying for MassHealth Limited or the Uncompensated Care Pool.

Personal-Care-Attendant Services (for people aged 65 or older who are not going into a long-term-care facility)

PCA

To get more information about personal-care-attendant (PCA) services, and how filling out this PCA section could affect the way we decide if you can get MassHealth if you do need PCA services, read the PCA section in the *MassHealth and You* guide that is enclosed.

▶ Do you or your spouse need the services of a personal-care attendant? . . . . . ☐ yes ☐ no

If **yes**, fill out this section and answer all questions.
If **no**, go to the next section (Income from Working).

▶ Have you or your spouse had the services of a personal-care attendant **paid for by MassHealth** within the last six months?

You . . . . . ☐ yes ☐ no
Your spouse . . . . ☐ yes ☐ no

If **yes**, go to the next section (Income from Working).
If **no**, answer the following three questions in this section.

▶ Do you or your spouse have a permanent or long-lasting disability?

You . . . . . ☐ yes ☐ no
Your spouse . . . . ☐ yes ☐ no

If **yes**, does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)?

You . . . . . ☐ yes ☐ no
Your spouse . . . . ☐ yes ☐ no

If **yes**, do you (or your spouse) plan to contact a MassHealth personal-care agency to ask for personal-care-attendant services?

You . . . . . ☐ yes ☐ no
Your spouse . . . . ☐ yes ☐ no

(Note: You must contact the personal-care agency within 90 days of the date that MassHealth decides you are eligible for MassHealth or you will not be able to benefit from the special PCA rules.)

MassHealth will not pay certain members of your family to be your personal-care attendant.

Each spouse who answered yes to the last three questions above must fill out his or her own Personal-Care-Attendant Supplement (gold form). One copy is enclosed. If you need a second copy, call the MassHealth Customer Service Center at 1-800-841-2900 to ask for one. If you (or your spouse) do not send us your filled–out PCA supplement(s) (gold form), we will determine your MassHealth eligibility as if you do not need PCA services.

Income from Working

EIN

▶ Are you or your spouse currently working or seasonally employed? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.
If **no**, go to the next section (Nonworking Income).

✉ **Send proof** of income, like a copy of two recent pay stubs. If self-employed, send a copy of your most recent federal tax return.

1. **Name**

Employer name, address, and telephone number	Type of work *(Check all that apply.)* ☐ full-time ☐ part-time ☐ self-employed ☐ day labor ☐ seasonal yearly wage: $ _____ ☐ sheltered workshop yearly wage: $ _____				**For office use only** (indicate weekly, biweekly, or monthly)	
					$	
					$	
Is health insurance offered?** ☐ yes ☐ no	Number of hours per week	Weekly pay before deductions $	Date began getting this amount of pay	HID	Hrs.	
					Hrs.	

2. **Name**

Employer name, address, and telephone number	Type of work *(Check all that apply.)* ☐ full-time ☐ part-time ☐ self-employed ☐ day labor ☐ seasonal yearly wage: $ _____ ☐ sheltered workshop yearly wage: $ _____				**For office use only** (indicate weekly, biweekly, or monthly)	
					$	
					$	
Is health insurance offered?** ☐ yes ☐ no	Number of hours per week	Weekly pay before deductions $	Date began getting this amount of pay	HID	Hrs.	
					Hrs.	

** Check yes even if you cannot get it now.

Please go to the next page. ▶

Nonworking Income

UIN

▶ Do you or any family member have any other income, including rental income? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (Health Insurance).

▶ Please describe the source of the income (where it comes from) for each family member.
If anyone has more than one source, list on separate lines below.

✉ **Send proof.** Some types of other income are:

- annuities
- veteran's benefits (federal)
- worker's compensation
- social security
- veteran's benefits (state or city)
- unemployment compensation
- pensions
- dividends or interest
- trusts
- retirement
- SSI
- roomer/boarder income
- other (please describe below)

Name	Type of income (all that apply from list above)	Source (where the income comes from)	Monthly amount before taxes	**For office use only**
			$	
			$	
			$	
			$	

Rental Income

REN

▶ Do you or your spouse have rental income? . . . . . ☐ yes ☐ no

If **yes**, fill out this section. Name(s): _____

If **no**, go to the next section (Health Insurance).

✉ **Send proof** of current rental income, like a written statement from each tenant or a copy of the lease, or a current federal tax return.

✉ **Send proof** of all of the following expenses, if applicable, for the last 12 months :

- mortgage
- taxes
- utilities (gas/electric)
- heat
- water/sewer
- insurance
- condo or co-op fee
- repairs and maintenance

▶ What type of real estate do you own?

☐ one-family ☐ two-family ☐ three-family ☐ other (describe): _____

▶ How much monthly rental income do you get from each rental unit from the real estate indicated above?
(List each rental unit and address separately.)

Address _____ Unit # _____ Amount $ _____ Owner-occupied? ☐ yes ☐ no

Address _____ Unit # _____ Amount $ _____ Owner-occupied? ☐ yes ☐ no

▶ Do you pay for heat and/or utilities for your tenant? . . . . . ☐ yes ☐ no

(List additional real estate on a separate sheet of paper.)

Please go to the next page. ▶

Health Insurance

Even if you or your spouse have other health insurance, MassHealth may be able to help you.

▶ Do you or your spouse have health insurance, or access to health insurance, including Medicare? . . . . . ☐ yes ☐ no

▶ Did you or your spouse leave a job within the last six months that offered health insurance? . . . . . ☐ yes ☐ no

If you answered **yes** to either of the above two questions, fill out the rest of this page.

If **no**, go to the next section (Accident Information).

Medicare

HIN

▶ Do you or your spouse who is applying get Medicare? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

1.	Name	Claim number
2.	Name	Claim number

Medicare Supplemental Insurance (for example, Medex or AARP)

▶ Do you or your spouse have Medicare supplemental insurance? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

	You	Your spouse
Insurance company name		
Policy number		
Policy start date		

Other Health Insurance (for example, HMO, dental, vision, long-term-care insurance)

EHI

If you or your spouse have health insurance, you may still be able to get MassHealth. Health insurance can be from an employer or any other source.

▶ Do you or your spouse have other health insurance? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

☒ **Send copies** of your current health-insurance premium bills if you are applying for long-term-care services in a medical facility. If you have more than one policy, or if you have other insurance like dental or vision, check here ☐, and use a separate sheet of paper. If you have long-term-care insurance, **send a copy** of the policy.

	You	Your spouse
Insurance company name		
Group number		
Employer or union name		
Policy start date		
Policy number		
Policyholder name		
Policyholder date of birth		
Policyholder social security number		
Policy type	☐ individual ☐ couple (2 adults) ☐ family ☐ dual (one adult, one child)	☐ individual ☐ couple (2 adults) ☐ family ☐ dual (one adult, one child)
Policyholder contribution to premium costs	$_____ per week $_____ per month $_____ per quarter	$_____ per week $_____ per month $_____ per quarter
Names of covered members		

Please go to the next page. ▶

Accident Information

TPR

You must answer the following three questions about you or your spouse who needs health care because of an accident or injury.

For office use only

- Are you or your spouse applying because of an accident or injury that someone else might be responsible for? . . . . . ☐ yes ☐ no
  If **yes**, names: _____
- Do you or your spouse have an injury, illness, or disability that was caused by someone else, or that could be covered by someone else's insurance or the family member's own insurance, other than health insurance (like homeowner's or auto insurance)? . . . . . ☐ yes ☐ no
  If **yes**, names: _____
- Has a lawsuit, a worker's compensation claim, or an insurance claim for an accident or injury been filed for you or your spouse who is applying? . . . . . ☐ yes ☐ no
  If **yes**, names: _____

Assets

ATT

You must fill out all blocks for each asset you or your spouse own. If you need more space, please use a separate sheet of paper and attach it to this application.

- If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period.
- If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the last 36 months. If you have a spouse at home, you also need to fill out the shaded blocks.*

Bank Accounts

- Do you or your spouse have any bank accounts or certificates of deposit, including checking, savings, credit union, NOW, money-market, and personal needs allowance (PNA) accounts? . . . . . ☐ yes ☐ no
- Do you or your spouse have any retirement accounts, including individual retirement accounts (IRAs), Keogh, or pension funds? . . . . . ☐ yes ☐ no
- Have you or your spouse or a joint owner closed any accounts in the last 36 months, including any accounts you had owned jointly with anyone else? . . . . . ☐ yes ☐ no

If you answered **yes** to **any** of these questions, fill out this section.

If you answered **no** to **all** of these questions, go to the next section (Life Insurance).

✉ **Send a copy** of your passbooks updated within 45 days and/or a copy of your current account statements.

Name on account	Name of bank/institution		Account number	Account type
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed	Date account closed	Amount on the date account closed $
Name on account	Name of bank/institution		Account number	Account type
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed	Date account closed	Amount on the date account closed $
Name on account	Name of bank/institution		Account number	Account type
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed	Date account closed	Amount on the date account closed $
Name on account	Name of bank/institution		Account number	Account type
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed	Date account closed	Amount on the date account closed $

* Enter the account balance on the date of admission to medical institution.

Please go to the next page. ▶

Life Insurance

ATT

▶ Do you or your spouse **own** any life insurance? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (Securities (Stocks/Bonds/Other)).

✉ **Send a copy** of the first page of all life-insurance policies. If total face value of all policies exceeds $1,500 per person, also send a letter from the insurance company showing the current cash-surrender value (for all policies except term policies).

Name(s) of owner(s)	Insurance company	Policy number	Face value	Insurance type
			$	
			$	
			$	

Securities (Stocks/Bonds/Other)

ATT

▶ Do you or your spouse own any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe-deposit boxes, or cash not in the bank? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (Annuities).

✉ **Send proof** of current value (except cash).

	Owner(s) name(s)	Company name	Account number	Current value	Value on admission date*	Joint asset?
Cash				$	$	☐ yes ☐ no
Stocks				$	$	☐ yes ☐ no
Bonds				$	$	☐ yes ☐ no
Savings bonds				$	$	☐ yes ☐ no
Mutual funds				$	$	☐ yes ☐ no
Options				$	$	☐ yes ☐ no
Future contracts				$	$	☐ yes ☐ no
Other				$	$	☐ yes ☐ no

Annuities

ATT

▶ Do you or your spouse own an annuity? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (Real Estate).

✉ **Send a copy** of the contract. For each annuity owned, give us proof from the annuity company of the full value of the annuity less any penalties and fees if it can be cashed in.

Name(s) of owner(s)	
Name of institution issuing the annuity	
Account number	
Name(s) of owner(s)	
Name of institution issuing the annuity	
Account number	

* Enter the account balance on the date of admission to medical institution.

Please go to the next page. ▶

Real Estate

ATT

▶ Do you or your spouse own or have a legal interest in any real estate other than your primary residence? . . . . . You ☐ yes ☐ no
. . . . . Your spouse ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (Vehicles/Mobile Homes).

✉ **Send a copy** of the deed(s), current tax bills(s), and proof of amount owed.

Address: _____ Type of property: _____

Address: _____ Type of property: _____

Vehicles/Mobile Homes

▶ Do you or your spouse own any vehicles, like cars, vans, trucks, recreational vehicles, mobile homes, boats, or any other kind? ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (Prepaid Burial Plans/Trusts).

✉ **Send a copy** of the registration for each vehicle, and proof of the outstanding loan balance. For mobile homes, **send a copy** of the bill of sale. If you have a spouse at home, **send proof** of the fair-market value of each vehicle as of the date of admission to the medical institution.

	You	Your spouse
Type of vehicle		
Year/make/model		
Fair-market value	$	$
Amount owed	$	$

Prepaid Burial Plans/Trusts

ATT

▶ Do you or your spouse have any prepaid burial contracts or trusts, life insurance set up for funeral and burial expenses, or bank accounts set aside for funeral expenses? . . . . . ☐ yes ☐ no

If **yes**, fill out this section. If **no**, go to the next section (Trusts).

✉ **Send a copy** of the trust contract, trust instrument, insurance policy, or burial-only account.

	You		Your spouse	
Burial contract	☐ yes (amount: $ _____)	☐ no	☐ yes (amount: $ _____)	☐ no
Burial trust	☐ yes (amount: $ _____)	☐ no	☐ yes (amount: $ _____)	☐ no
Life insurance for burial	☐ yes (total face value: $ _____)	☐ no	☐ yes (total face value: $ _____)	☐ no
Burial-only account	☐ yes (amount: $ _____)	☐ no	☐ yes (amount: $ _____)	☐ no
Burial plot	☐ yes	☐ no	☐ yes	☐ no

Trusts

ATT

▶ Are you or your spouse the grantor/donor, trustee, or beneficiary of any trusts? . . . . . ☐ yes ☐ no

▶ Have you, your spouse, or someone else on your behalf, including a court or administrative body, contributed income or assets owned by you or your spouse to a trust? . . . . . ☐ yes ☐ no

If you answered **yes** to any of these questions, fill out this section.

If you answered **no** to these questions, go to the next section (Citizenship).

✉ **Send a copy** of the trust document(s) showing financial activity and the schedule of beneficiaries.

Trust name	Revocable?	Current trust principal	Trust principal on admission date*	Trustee(s)	Grantor(s)/Donor(s)	Beneficiaries
	☐ yes ☐ no	$	$			
	☐ yes ☐ no	$	$			

* Enter the trust principal on the date of admission to medical institution.

Please go to the next page. ▶

Assets (cont.)

▶ Have you, your spouse, or someone acting on your behalf given a deposit to any health-care or residential facility, like an assisted-living facility? . . . . . ☐ yes ☐ no

If **yes**, give us the name and address of the facility, the amount of the deposit, and the date it was given to the facility.

✉ **Send a copy** of the facility's documents about this deposit.

Name of facility	Address of facility	Amount	Date
		$	

Citizenship

If you and your spouse **are** U.S. citizens, you do not have to fill out the rest of this page. Go to page 9.

If either you and your spouse **are not** U.S. citizens, and you are applying, you must fill out the rest of this page.

▶ 1. Are you or your spouse a veteran of the United States Armed Forces with an honorable discharge or did you or your spouse serve under U.S. command during World War II or in Vietnam? . . . . . ☐ yes ☐ no

If **yes**, you may stop here and go to page 9.

If **no**, go to the next question.

▶ 2. Are you or your spouse the widow or widower of a veteran described above? . . . . . ☐ yes ☐ no

If **yes**, you may stop here and go to page 9.

If **no**, go to the next question.

▶ 3. Are you or your spouse a victim of domestic abuse and no longer living with the abuser? . . . . . ☐ yes ☐ no

If **yes**, you may stop here and go to page 9.

If **no**, you must fill out the rest of this page (Immigration Status).

Immigration Status

QAC

▶ List all statuses that have applied to you or your spouse since entering the U.S.

✉ **Send copies** of both sides of all immigration cards (or other documents that show immigration status).

Note: If you and your spouse are applying only for MassHealth Limited or the Uncompensated Care Pool, you do not have to give us a social security number. We will not match your names with any other agency including the Department of Homeland Security (DHS). You do not have to list your names on this page or send proof of your immigration status. MassHealth Limited pays for emergency services only.

Use these codes to describe your status in the chart below.

4. Amerasian admitted pursuant to Section 584 of Public Law 100-202
5. Granted asylum
6. Conditional entrant
7. Cuban/Haitian entrant
8. Deportation withheld
9. Legal permanent resident
10. Native American with at least 50% American Indian blood born in Canada
11. Granted parole
12. Refugee
13. Person with a temporary visa/other
14. Person residing under color of law (PRUCOL)
15. Victim of severe forms of trafficking

Name	Status codes (List all that apply.)	Date status awarded	U.S. entry date	**For office use only**

Please go to the next page. ▶

Fill out this section ONLY if you are a member of a married couple living with your spouse and:

- **are less than 65 years of age, and**
- **are applying for MassHealth, and**
- **have no children under age 19 living with you.**

If this section applies to you and you want more information about income standards and other information that may apply to you, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss) to get a MassHealth Member Booklet.

If this section does not apply to you, go to page 10.

Not Working

LTU

▶ Are you **unemployed**, only working from time to time, or retired? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (HIV Information (optional)).

Name: _____

▶ Is this person getting unemployment benefits? . . . . . ☐ yes ☐ no

▶ Has this person worked in the past 12 months? . . . . . ☐ yes ☐ no

If **yes**, how much did this person earn in the past 12 months before taxes and deductions? $ _____

▶ Is this person a college student? . . . . . ☐ yes ☐ no

If **yes**, is this person eligible for health insurance from the college? ☐ yes ☐ no

▶ Is your spouse working 100 hours or more a month? . . . . . ☐ yes ☐ no

HIV Information (optional)

HIV

MassHealth may give benefits to people who are HIV positive who might not otherwise be eligible.

▶ Do you want to apply for these benefits? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

If **no**, go to the next section (Disability (only for persons under 65 years of age)).

✉ **Send proof** of income and HIV-positive status. If proof of HIV-positive status is not attached, you may get benefits for up to 60 days while we wait for proof. For more information, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss) and ask for a MassHealth Member Booklet.

Name: _____

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Disability (only for persons under 65 years of age)

PDI/ DDU

▶ Do you have a disability that has lasted or is expected to last for at least 12 months? . . . . . ☐ yes ☐ no

If **yes**, answer the next three questions.

If **no**, go to page 10.

Name: _____

For office use only

Supp to DES	Dis type

▶ Does this person get money from Social Security for a disability? . . . . . ☐ yes ☐ no

▶ Has this person ever gotten Supplemental Security Income (SSI)? . . . . . ☐ yes ☐ no

▶ Is this person legally blind? . . . . . ☐ yes ☐ no

✉ If **yes**, send a copy of the Certificate of Blindness.

You must read the next page carefully and sign. ▶

This is an application for MassHealth and the Uncompensated Care Pool.

You, your spouse, and/or your eligibility representative must read this page carefully, then sign and date it at the bottom.

I give permission for my current and former employers and health insurers to release to MassHealth any and all information they have about my health-insurance coverage and health-insurance coverage for my spouse. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to me or my spouse.

I give permission to MassHealth to get any records or data to prove any information given on this application and any supplements, or other information I give to MassHealth once I am a member. If I or my spouse is found eligible for MassHealth, I give permission to MassHealth to get any medical records about medical services provided through MassHealth.

I understand that in some cases, MassHealth may place a lien against any real estate that I have a legal interest in. If MassHealth puts a lien against my property and I sell it, I may need to use money I get from the sale of that property to repay MassHealth for medical services that I get.

I understand that if I am aged 55 or older, after I die, MassHealth may be able to get back money from my estate.

I understand that if I or my spouse is in an accident, or we are injured in some other way, and get money from a third party because of that accident or injury, we will need to use that money to repay MassHealth for certain medical services provided, as explained in the *MassHealth and You* guide. I also understand that I must tell MassHealth in writing, within 10 days, if I or my spouse files any insurance claim or lawsuit because of an accident or injury to me or my spouse.

I understand that if I or my spouse is eligible for MassHealth or the Uncompensated Care Pool, I must tell MassHealth of any changes in my or my spouse's income or employment, assets, health-insurance coverage, health-insurance premiums, and immigration status, or of changes in any other information I gave on this application and any supplements within 10 days of learning of the change.

I also understand that by signing below, I give permission to MassHealth to go after and collect third-party payments for medical care and medical support from my spouse who is living at home and refuses to cooperate or whose whereabouts is unknown.

I certify that I have read or have had read to me the information on this application and any supplements, and the information in the *MassHealth and You* guide, and that I understand my rights and responsibilities. I further certify under penalty of perjury that the information on this application and any supplements is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this application and any supplements, the enclosed MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this application. Your signature on this application and any supplements as an eligibility representative certifies that the information on this application and any supplements is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal or file a grievance. If you are denied benefits, you will get information about how to appeal a MassHealth decision and also how to file a grievance about any Uncompensated Care Pool decision.

X _____ _____

Signature of applicant or eligibility representative — Date

X _____ _____

Signature of applicant's spouse or spouse's eligibility representative — Date

Clear entire form.

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Supplement A: Long-Term-Care Questions

For office use only
Head of household/applicant name:
Head of household/applicant SSN:

▶ Do you need long-term-care services? . . . . . ☐ yes ☐ no

If **yes**, you must fill out this supplement.

Please print clearly. Answer all questions and fill out all sections. If you need more space to finish any section, please use a separate sheet of paper and attach it to this supplement.

Head of Household/Applicant Information

Last name	First name	MI	Social security number

▶ Do you have to pay guardianship expenses for a court-appointed guardian? . . . . . ☐ yes ☐ no

Living expenses of the spouse and family members living at home

Your spouse living at home may be able to keep some of your income. Fill out the following information about your spouse's current living expenses.

If you **do not** have a spouse, go to the next section (Long-Term-Care Insurance).

✉ **Send proof** of your spouse's current living expenses.

▶ 1. How much does your spouse pay each month for:

Rent?	Mortgage (principal and interest)?	Homeowner's/tenant's insurance?	Real estate taxes?	Required maintenance charge for a condo or co-op?	Room and board for assisted living?
$	$	$	$	$	$

▶ 2. Does your spouse pay for heat?. . . . . ☐ yes ☐ no

▶ 3. Does your spouse pay for utilities? . . . . . ☐ yes ☐ no

▶ 4. Is a child, parent, brother, and/or sister living with your spouse? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.
If **no**, go to the next section (Long-Term-Care Insurance).

✉ **Send proof** of their monthly income before deductions.

A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.

Name	Social security number	Relationship	Date of birth	Monthly income before deductions
				$
				$

Long-Term-Care Insurance

▶ Do you or your spouse have long-term-care insurance? . . . . . ☐ yes ☐ no

If **yes,** fill out this section.
If **no,** go to the next section (Real Estate).

✉ **Send a copy** of the policy.

Company name/Policy number	Policyholder name	Effective date	Premium amount
			$
			$

Please go to the next page. ▶

Real Estate

The answers to the following questions will be used to decide if: (1) your real estate will be counted as an asset; or (2) a lien will be placed against your real estate. Your home is a noncountable asset if you intend to return to it. Your home may be subject to a lien. However, if you own long-term-care insurance that meets certain requirements when you enter a long-term-care facility, your home is noncountable regardless of your intent to return.

▶ 1. Do you or your spouse own or have a legal interest in your home, including a life estate? . . . . . ☐ yes ☐ no

If **yes**, fill out the following information and answer questions 2 through 4.

If **no**, answer question 4 only.

Name and address of person(s) on ownership papers	Description and address of property location	Fair-market value
		$
		$

▶ 2. Do you have a	**If you answered yes,** fill out this column and the next.	Is this person living in your home?
spouse? . . . . . ☐ yes ☐ no	Name:	☐ yes ☐ no
permanently and totally disabled or blind child? . . . . . ☐ yes ☐ no	Name:	☐ yes ☐ no
child under 21 years of age? . . . . . ☐ yes ☐ no	Name: Date of birth:	☐ yes ☐ no
brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? . . . . . ☐ yes ☐ no	Name:	☐ yes ☐ no
son or daughter who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home? . . . . . ☐ yes ☐ no	Name:	☐ yes ☐ no
dependent relative? . . . . . ☐ yes ☐ no	Name: Describe the relationship and the nature of the dependency:	☐ yes ☐ no

▶ 3. Do you intend to return to your home within the next six months? . . . . . ☐ yes ☐ no

▶ 4. Do you or your spouse own or have a legal interest in other real estate not listed in #1 above? . . . . . ☐ yes ☐ no

If **yes,** please describe the property and list its address below.

Please go to the next page. ▶

Resource Transfers (resources include both income and assets)

▶ 1. In the last 36 months:

a. Did you, your spouse, or someone on your behalf transfer income or the right to income? ☐ yes ☐ no

b. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate? ☐ yes ☐ no

c. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate? ☐ yes ☐ no

d. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? ☐ yes ☐ no

e. Did you, your spouse, or someone on your behalf give anyone a mortgage or promissory note on property you own? ☐ yes ☐ no

▶ 2. In the last 60 months, has any property available or belonging to you or your spouse been transferred into or out of a trust of which you or your spouse are or had been a beneficiary, trustee, or grantor? ☐ yes ☐ no

If you answered **yes** to any of the questions above, you must fill out the following.

Description of asset/income	Dates of transfer	Transferred to whom	Relationship to you or your spouse	Amount of transfer
				$
				$
				$

▶ 3. Have you, your spouse, or someone acting on your behalf given a deposit to any health-care or residential facility, like an assisted-living facility? ☐ yes ☐ no

If **yes**, give us the name and address of the facility, and the amount of the deposit, and answer the following questions.

Name of facility	Address of facility	Amount
		$

a. Does the facility still have the deposit? ☐ yes ☐ no

b. Did the facility return the deposit? ☐ yes ☐ no

If **yes**, give us the name and address of the person who got the deposit from the facility.

Name of person	Address

Tax Returns

▶ Did you or your spouse file U.S. income tax returns in the last two years? ☐ yes ☐ no

✉ If **yes**, you must **send copies** of these returns. If you did not keep copies of your tax returns for the last two years, **you must send a filled-out and signed Form 4506 to the Internal Revenue Service.** Form 4506 is included as part of this application.

Back to page 1 of the SMBR application.